FISCAL YEAR 2006
STATE OF GEORGIA
ANNUAL PERSONAL CARE HOME SURVEY
July 1, 2005 – June 30, 2006

PART A: GENERAL INFORMATION

1. Identification:

FACILITY NAME:		COUNTY:
STREET ADDRESS	CITY:	STREET ZIP:
MAIL ADDRESS:	CITY:	MAIL ZIP:

2. Report Period:

Report data for the period of July 1, 2005 through June 30, 2006 (365 days). Do not use a different report period.
Was the facility operational for the entire year? [ ] YES [ ] NO
If NO, provide the dates the facility was operational (explain):

PART B: CONTACT INFORMATION

Person authorized to respond to inquiries about the responses to this survey: Name: Title:		
Telephone:	Fax:	E-Mail:

PART C: OWNERSHIP, PROGRAMS & LICENSURE

OWNERSHIP, OPERATION AND MANAGEMENT as of the last day of the Report Period. Provide full legal name for each CATEGORY. Use the following organization types to describe the owner/operator status for your organization or leave blank if a category is "not applicable".

Individual
Hospital Authority — Local Government
For Profit Corporation — State
Not For Profit Corporation — Federal

CATEGORY	FULL LEGAL NAME	ORGANIZATION TYPE	EFFECTIVE DATE M/D/Y
a. FACILITY OWNER			
b. OWNER'S PARENT ORG			
c. FACILITY OPERATOR			
d. OPERATOR'S PARENT ORG			
e. MGMT. CONTRACTOR			
f. MGMT'S PARENT ORG			

2. Is the operator, if any, reported in C.1.c: A. LESSEE?
B. SUBLESSEE?

3. Did your facility have any **changes** for questions C.1.a. through C.1.f. above:

A. DURING the Report Period?
B. SINCE THE LAST DAY of the Report Period?

***If YES**, provide in the box below a list of the parties involved and the date of change.*

4. As of the last day of the Report Period did the Owner(s) reported in question C.1.a./b. above also ***own or operate*** any other personal care home(s) and/or any other health care facility in Georgia?

***If YES**, please provide in the box below a list of facilities, including the city and county of each location.*

PART C: (cont.)

5. **ORGANIZATIONAL AFFILIATIONS** as of the last day of the Report Period. Indicate if your facility has any affiliations with the following: **[see definitions]**

a. Is the facility organizationally related to a retirement complex? YES _____ NO _____

If YES, its legal/licensed name:

b. Is the facility organizationally related to a nursing home? YES _____ NO _____

If YES, its legal/licensed name:

c. Is the facility organizationally related to a hospital? YES _____ NO _____

If YES, please indicate what best describes your location:

1) within a hospital _____ 2) on hospital grounds only _____ 3) off hospital grounds _____

If YES, hospital's legal/licensed name:

d. **Is the facility organizational related to a hospice?** YES _____ NO _____

If YES, its legal/licensed name: _____

6. **SPECIAL PROGRAMS** Please indicate if your facility provides any of the following programs.

a. Alzheimer's disease? YES _____ NO_____

b. Respite care? YES _____ NO_____

c. Mental Retardation/Mental Health Residential? YES _____ NO_____

d. Adult day care? YES _____ NO_____

e. Any other? YES _____ NO_____

Specify

PART D: BEDS AND UTILIZATION

1. ADMISSIONS, DISCHARGES & DISCHARGED DAYS OF CARE: --

Report Items a. through d. for the current Report Period **7/1/05 to 6/30/06**

a. Resident Occupancy as of **6/30/05**	
b. Total Admissions	
c. Total Live Discharges	
d. Total Discharges Due to Death	
Total Resident Occupancy as of **6/30/06**	

2. TOTAL RESIDENTS on the last day of the Report Period (6/30/06) provided by age, sex, and race/ethnicity. **Do not** substitute admissions for residents. The Total All Ages column must equal the Total All Race/Ethnicity column. In addition, these Totals must match the calculated Total Resident Occupancy from D1 and Part F.

SEX OF RESIDENT	TOTAL RESIDENTS BY AGE GROUP				
	AGES 0-14	AGES 15-64	AGES 65-74	AGES 75-84	AGES 85+
MALE					
FEMALE					

(TOTAL ALL AGES MUST EQUAL TOTAL RACE/ETHNICITY)

3. TOTAL RESIDENTS by Race/Ethnicity on the last day of the Report Period.

RESIDENTS BY RACE/ETHNICITY						
American Indian/Alaska Native	Asian	Black/African American	Hispanic or Latino	Hawaiian/ Pacific Islander	White	Multi-Racial

4. Total beds set up and staffed (all beds both occupied and vacant) as of June 30, 2006.	

5. Report the average percent of persons living at your facility who pay by private insurance (long term care insurance).	
6. Report the Average Daily Occupancy (number of beds rented) during the Report Period.	
7. What is the average monthly charge for room and board (no extra services) for the Report Period?	

Part E: Financial Data and Indigent/Charity Care

1. **INDIGENT/CHARITY CARE POLICIES:** Did the home have a formal written policy or written policies during State Fiscal Year 2006 concerning the provision of care to residents who are indigent (income at or less than 125% of the federal poverty level) or who qualify for charity care (income above 125% of the federal poverty level as defined by the policy)? Yes____ No_____

2. **FINANCIAL DATA:** Please provide the following financial data for State Fiscal Year 2006 (7/1/05 to 6/30/06). Responses should be limited to financial data from the personal care home program only. Gross Revenue should reflect total billings for all personal care home services during the year for all residents billed. Bad Debt should reflect any portion of the billings that residents legally owed but failed to pay. Indigent and Charity Care reflects service costs that were written off or forgiven by the home because the resident qualified for indigent or charity care pursuant to state law or the home's charity policy. In case of indigent or charity care, the resident is authorized by the home to receive free services or services at a reduced cost. The number of residents is the total number that contributed to the revenue for the year.

Financial Category	Dollar Amount	Number of Residents
Gross Revenue (Gross Charges associated with Patient care.)		
Bad Debt (Unpaid bills for which payment was expected.)		
Indigent and Charity Care (Free or reduced cost of care provided to personal care home residents.)		

All facilities are required to complete the financial section. Some Personal Care Homes have Indigent and Charity Care Commitments associated with Certificate of Need authorizations. Georgia law requires the reporting of the financial and indigent/charity care information requested above in order to evaluate these commitments.

PART F: CURRENT RESIDENT ORIGIN

For the total resident census reported in Part D.1, D.2, and D.3 provide the number of residents from each Georgia county and from other States. This should reflect the Georgia county or other state where the resident was living on a permanent basis before he/she was admitted to your facility. **Totals for Parts D.1, D. 2, D.3, and Part F must agree.**

1. APPLING		44. DEKALB		87. LAURENS		130. TALBOT	
2. ATKINSON		45. DODGE		88. LEE		131. TALIAFERRO	
3. BACON		46. DOOLY		89. LIBERTY		132. TATTNALL	
4. BAKER		47. DOUGHERTY		90. LINCOLN		133. TAYLOR	
5. BALDWIN		48. DOUGLAS		91. LONG		134. TELFAIR	
6. BANKS		49. EARLY		92. LOWNDES		135. TERRELL	
7. BARROW		50. ECHOLS		93. LUMPKIN		136. THOMAS	
8. BARTOW		51. EFFINGHAM		94. MACON		137. TIFT	
9. BEN HILL		52. ELBERT		95. MADISON		138. TOOMBS	
10. BERRIEN		53. EMANUEL		96. MARION		139. TOWNS	
11. BIBB		54. EVANS		97. MCDUFFIE		140. TREUTLEN	
12. BLECKLEY		55. FANNIN		98. MCINTOSH		141. TROUP	
13. BRANTLEY		56. FAYETTE		99. MERIWETHER		142. TURNER	
14. BROOKS		57. FLOYD		100. MILLER		143. TWIGGS	
15. BRYAN		58. FORSYTH		101. MITCHELL		144. UNION	
16. BULLOCH		59. FRANKLIN		102. MONROE		145. UPSON	
17. BURKE		60. FULTON		103. MONTGOMERY		146. WALKER	
18. BUTTS		61. GILMER		104. MORGAN		147. WALTON	
19. CALHOUN		62. GLASCOCK		105. MURRAY		148. WARE	
20. CAMDEN		63. GLYNN		106. MUSCOGEE		149. WARREN	
21. CANDLER		64. GORDON		107. NEWTON		150. WASHINGTON	
22. CARROLL		65. GRADY		108. OCONEE		151. WAYNE	
23. CATOOSA		66. GREENE		109. OGLETHORPE		152. WEBSTER	
24. CHARLTON		67. GWINNETT		110. PAULDING		153. WHEELER	
25. CHATHAM		68. HABERSHAM		111. PEACH		154. WHITE	
26. CHATTAH.		69. HALL		112. PICKENS		155. WHITFIELD	
27. CHATTOOGA		70. HANCOCK		113. PIERCE		156. WILCOX	
28. CHEROKEE		71. HARALSON		114. PIKE		157. WILKES	
29. CLARKE		72. HARRIS		115. POLK		158. WILKINSON	
30. CLAY		73. HART		116. PULASKI		159. WORTH	
31. CLAYTON		74. HEARD		117. PUTNAM			
32. CLINCH		75. HENRY		118. QUITMAN		OUT-OF-STATE	
33. COBB		76. HOUSTON		119. RABUN		160. ALABAMA	
34. COFFEE		77. IRWIN		120. RANDOLPH		161. FLORIDA	
35. COLQUITT		78. JACKSON		121. RICHMOND		162. N. CAROLINA	
36. COLUMBIA		79. JASPER		122. ROCKDALE		163. S. CAROLINA	
37. COOK		80. JEFF DAVIS		123. SCHLEY		164. TENNESSEE	
38. COWETA		81. JEFFERSON		124. SCREVEN		165. OTHER STATES	
39. CRAWFORD		82. JENKINS		125. SEMINOLE		TOTAL	
40. CRISP		83. JOHNSON		126. SPALDING			
41. DADE		84. JONES		127. STEPHENS			
42. DAWSON		85. LAMAR		128. STEWART			
43. DECATUR		86. LANIER		129. SUMTER			

PART G: ELECTRONIC SIGNATURE AND CONTRACT

Please note that the survey WILL NOT BE ACCEPTED without the authorized signature of the Chief Executive Officer, Executive Director or Principal Administrator of the facility pursuant to Rule 111-2-2-.04(1)(6). The signature can be completed only AFTER all survey data has been finalized. By law, the signatory is attesting under penalty of law that the information is accurate and complete.

I state, certify and attest that to the best of my knowledge upon conducting due diligence to assure the accuracy and completeness of all data, and based upon my affirmative review of the entire completed survey, this completed survey contains no untrue statement, or inaccurate data, nor omits requested material information or data. I further state, certify and attest that I have reviewed the entire contents of the completed survey with all appropriate staff of the facility. I understand that inaccurate, incomplete or omitted data could lead to sanctions against me or my facility. I further understand that a typed version of my name is being accepted as my original signature pursuant to the Georgia Electronic Records and Signature Act.

Authorized Signature: _____ Date:

Title of Signer: _____